STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A SULDING A SULDING A SULDING COMPLETED ORALE OF PROVIDER OR SUPPLIER CLAY COUNTY MANOR INC STREET ADDRESS, CITY, STATE LEP CODE 129 PITCOCK LANK CELINA, TN 3851 STREET ADDRESS, CITY, STATE LEP CODE 129 PITCOCK LANK CELINA, TN 3851 STREET ADDRESS, CITY, STATE LEP CODE 129 PITCOCK LANK CELINA, TN 3851 STREET ADDRESS, CITY, STATE LEP CODE 129 PITCOCK LANK CELINA, TN 3851 F241 483,15(a) DIGNITY AND RESPECT OF SS=D INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each residents for dignity and respect in full recognition of his or her individuality, This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility falled to ensure the dignity was maintained for three residents (#7, #17, and #18) of eigitteen residents reviewed. The findings included: Cobservation of the dining room on September 14, 2010, at 11: 40 a.m., revealed resident # 7 and resident #17 seated at the same table. Continued observation revealed all other residents in interview with the Director of Nursing and Dictary Manager on Sept. 14, 2010 At 12:05 p.m. Interview with the Director of Nursing on September 13, 2010, at 4:00 p.m., in the Administration of a medication administration on September 13, 2010, at 3:30 p.m., revealed LPN 22 (Licensed Practical Nurse) administration medication to resident #18 through a PEC (percutaneous endoscopic) east totorous) bee.			H AND HUMAN SERVICES	45	L 10/30/10	PRINTED: 09/20/201 FORM APPROVE OMB NO. 0938-039	D
NAME OF PROVIDER OR SUPPLIER CLAY COUNTY MANOR INC CAY DUTION AND RESERVED OF PROVIDERS SUMMARY STATEMENT OF DEFICIENCIES PREFIX	STATEMEN'	T OF DEFICIENCIES	(X1) FROVIDER/SUPPLIER/CLIA	1 '		(X3) DATE SURVEY	_
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The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the dignity was maintained for three residents (#7, #17, and # 18) of eighteen residents reviewed. The findings included: Observation of the dining room on September 14, 2010, at 11: 40 a.m., revealed residents #7 and resident #17 seated at the same table. Continued observation revealed all other residents in the dining area had received the lunch trays at 11:50 a.m., and we're eating. Further observation revealed resident #7 and #17 did not receive a tray until 12:05 p.m. Interview with the Director of Nursing on September 15, 2010, at 4:00 p.m., in the Administrator's office, confirmed the residents had a delay in receiving their lunch trays. Observation of a medication administration on September 13, 2010, at 3:30 p.m., revealed LPN #2 (Licensed Practical Nurse) administration on providing privacy to residents during (percutaneous endoscopic gastrostorny) tube.	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	DULD BE COMPLETION	ų
Continued observation revealed LPN #2 did not medication administrations.	\$\$=D	INDIVIDUALITY The facility must promanner and in an elegan resident recognition of his recognition of his REQUIREMENT by: Based on observational failed to ensure the three residents (#7, residents reviewed. The findings included the findings included to ensure the three residents (#7, residents reviewed. The findings included the findings included the ensure the three residents (#7, residents reviewed.) The findings included the findings are a had recogned are a had recogned the ensure that the proview with the Discovery and the ensure that the province with the Discovery and the ensure that a delay in received the ensure that a delay in received the ensure that the province of a medication to resided the ensure that the province that the ensure that t	omote care for residents in a environment that maintains or ident's dignity and respect in its or her individuality. NT is not met as evidenced ion and interview, the facility dignity was maintained for #17, and #18) of eighteen ed: dining room on September 14, i., revealed resident #7 and if at the same table. Continued ed all other residents in the eived the lunch trays at 11:50 ng. Further observation 7 and #17 did not receive a price to of Nursing on 0, at 4:00 p.m., in the period their lunch trays. edication administration on 0, at 3:30 p.m., revealed LPN cal Nurse) administering ent #18 through a PEG oscopic gastrostomy) tube. Ition revealed LPN #2 did not	F 241	This Plan of Correction is submirequired under State and Federa The facility's submission of the I Correction does not constitute a admission on the part of the facility the findings constitute a deficient the scope and severity determine correct. Because the facility male such admissions, the statement the Plan of Correction cannot be against the facility in any subsequence administrative or civil proceeding. F241 1. Lunch trays were provided Residents #7 and #17 by the of Nursing and Dietary Mana Sept. 14, 2010 At 12:05 pm. The Director of Nursing immediated the blinds during the administration of the medical Res #18 so that the resident of privacy for the remainder of medication administration providing privacy to resident providing privacy to resident providing privacy to resident.	al law. Plan of an allity ate, that act, or that action is kes no ts made in e used quent g. Completin Date 9/25/2010 I to Director ager on acdiately tions for did have the rocess. was ac /10 on	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Jack Boone

Advistantes

9/29/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/2010 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	NULTIPLE CONSTRUCTION	(X3) DATE SI COMPLE	
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	PROVIDER OR SUPPLIER OUNTY MANOR INC	****	•	STREET ADDRESS, CITY, STATE, ZIP CO 120 PITCOCK LANE CELINA, TN 38551	ODE	-
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Administration.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 09/20/2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER. AND PLAN OF CORRECTION A. BUILDING B, WING 09/15/2010 445445 STREET ADDRESS, CITY, STATE, ZIP GODE NAME OF PROVIDER OR SUPPLIER 120 PITCOCK LANE CLAY COUNTY MANOR INC CELINA, TN 38551 PROVIDER'S PLAN OF CORRECTION ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE IEACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) The meal service arrangements were F 241 483.15(a) DIGNITY AND RESPECT OF SS=D INDIVIDUALITY altered on 9/16/10 by the Dietary Manager to ensure that all residents The facility must promote care for residents in a including # 7 and # 17 were served in manner and in an environment that maintains or a timely and consistent manner. enhances each resident's dignity and respect in full recognition of his or her individuality. The Director of Nursing and/or the Regional Director of Clinical This REQUIREMENT is not met as evidenced Services inserviced the licensed nurses and Certified Nursing Based on observation and interview, the facility Assistants on 9/13-14/2010 related to failed to ensure the dignity was maintained for Dignity, Respect, and Privacy issues. three residents (#7, #17, and # 18) of eighteen Additional inservices were conducted residents reviewed. by the Director of Nursing on The findings included: 9/15/10, 9/17/10, and 9/23/10. Observation of the dining room on September 14, 4. Meal Service arrangements will be 2010, at 11: 40 a.m., revealed resident # 7 and monitored by the Administrator or resident #17 seated at the same table. Continued observation revealed all other residents in the Director of Nursing for three days on dining area had received the lunch trays at 11:50. all three meals. One random service a,m., and were eating. Further observation per day will then be monitored by the revealed resident #7 and #17 did not receive a Dietary Manager five times per week tray until 12:05 p.m. for one week and then two times per Interview with the Director of Nursing on week for three months or until 100% September 15, 2010, at 4:00 p.m., in the compliance is achieved to ensure that Administrator's office, confirmed the residents all residents are served in a timely had a delay in receiving their lunch trays. and consistent manner. Observation of a medication administration on September 13, 2010, at 3:30 p.m., revealed LPN #2 (Licensed Practical Nurse) administering medication to resident #18 through a PEG (percutaneous endoscopic gastrostomy) tube. Continued observation revealed LPN #2 did not provide privacy for the resident prior to administering the medication. (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Admistrator

9/29/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other sefeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 09/20/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING e. WING 445445 09/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 PITCOCK LANE CLAY COUNTY MANOR INC **CELINA, TN 38551** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION 1D SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR USC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) The Director of Nursing will monitor 483, 15(a) DIGNITY AND RESPECT OF INDIVIDUALITY one random medication SS=D administration on each shift five The facility must promote care for residents in a times per week for one week and then manner and in an environment that maintains or two times per week for three months enhances each resident's dignity and respect in to ensure privacy for the residents full recognition of his or her individuality. prior to administering medications... All results of the above will be This REQUIREMENT is not met as evidenced reported monthly to the Quality bv: Assurance committee comprised of Based on observation and interview, the facility failed to ensure the dignity was maintained for the Medical Director, Administrator, three residents (#7, #17, and # 18) of eighteen Director of Nursing, Staffing residents reviewed. Coordinator, Minimum Data Set Coordinator, Social Services, The findings included: Activities Director, Dietary Manager, Observation of the dining room on September 14, and Housekeeping Supervisor. 2010, at 11: 40 a.m., revealed resident # 7 and resident #17 seated at the same table. Continued observation revealed all other residents in the dining area had received the lunch trays at 11:50 a.m., and were eating. Further observation revealed resident #7 and #17 did not receive a tray until 12:05 p.m. Interview with the Director of Nursing on September 15, 2010, at 4:00 p.m., in the Administrator's office, confirmed the residents

provide privacy for the resident prior to administering the medication.

had a delay in receiving their lunch trays.

Observation of a medication administration on September 13, 2010, at 3:30 p.m., revealed LPN #2 (Licensed Practical Nurse) administering medication to resident #18 through a PEG (percutaneous endoscopic gastrostomy) tube. Continued observation revealed LPN #2 did not

LABORATORX DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Admistrator

9/29/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF BEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	A. BUI		PLE CONSTRUCTION 3	(X3) DATE SUI COMPLET	
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NAME OF PROVIDER OR SUPPLIER CLAY COUNTY MANOR INC		•	12	EET AODRESS, CITY, STATE, ZIP 20 PITCOCK LANE ELINA, TN 38551	CODE	
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' 2010, at 3:50 p.m.,	PN #2 on September 13, in the hallway, confirmed vided for the resident prior to	F	241			
the resident to use to the extent possible to the extent possible. This REQUIREMENT by: Based on observation failed to ensure a control of the findings included to the findings included the findi	ovide a safe, clean, melike environment, allowing his or her personal belongings sie. IT is not met as evidenced on and interview the facility lean and sanitary environment.		252	 Rust remover and the brown removed by the Supervisor on An assessment areas was con Housekeeping 9/14/10 to ensigned areas were aff The Housekeet Department we 9/23/10 by the regarding protechniques to and sanitary etc. All flooring a monitored by Housekeeping daily for five flooring will to monitored by Housekeeping times per weekeeping times per weekeeping 	areas were ne Housekeeping 19/14/10. It of all flooring ducted by the 2 Supervisor on sure that no other rected. Exping I sa inserviced on the Administrator per cleaning the ensure a clean the environment. The environment	Completion Date 9/25/2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE S COMPL	
		445445	e. Wir	NG		09/	15/2010
	PROVIDER OR SUPPLIER		•	12	EET ADDRESS, CITY, STATE, ZIP CODE 20 PITCOCK LANE ELINA, TN 38551		
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F 241	2010, at 3:50 p.m.,	PN #2 on September 13, in the hallway, confirmed vided for the resident prior to	Fź	241	are properly cleaned and the environment is sanitary or until 100% compliance is achieved. All results will be reported monthly to the Quality Assurance commi	oe	
SS=C	ENVIRONMENT The facility must pro		Fź	252		ing	
;	the resident to use to the extent possib			ļ	Services, Activities Direct Dietary Manager, and Housekeeping Supervisor		
1	by: Based on observation	IT is not met as evidenced on and interview the facility ean and sanitary environment.					
	The findings include	ed;					
,	13, 2010, at 9:40 a.:	the initial tour on September m., of the shower room on the ed several areas of brown					
i	at the time of obser	#1 (Licensed Practical Nurse) vation confirmed the brown cleaned off the floor.			,		
;	2010, at 9:45 a.m.,	initial tour on September 13, revealed in room #310 the several areas that were			,		; ;
; 	Interview with the D	ON (Director of Nursing) on					



DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1.	MULTIF MULTIF	PLE CONSTRUCTION B	(X3) DATE Ŝ COMPL	
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:	bathroom of room # stains on the bathro Observation on Set of the whirlpool roo the floor had areas Interview with the D	O, at 8:00 a.m., in the #310, confirmed the brown floor. Intermber 13, 2010, at 2:10 p.m. on the 300 halfway revealed of brown debris stains. FON on September 13, 2010, whirlpool room, confirmed the rown debris.	,	252	F280 1. The care plan for re was immediately up	dated by	Completion Date 09/25/2010
SS=D	The resident has the incompetent or other incapacitated under participate in plannichanges in care and A comprehensive assinterdisciplinary teaphysician, a register for the resident, and disciplines as deter and, to the extent put the resident, the resident, the resident and revised by a teach assessment.	e right, unless adjudged erwise found to be the laws of the State, to ng care and treatment or			the Minimum Data Coordinator to refle resident's transfer n 9/15/10. 2. An audit of all reside plans was conducted Director of Nursing Minimum Data Set Coordinator, and th Coordinator on 9/15 assess for problem identification and a intervention identifi 3. The Minimum Data Coordinator was intervention was intervention about the care plant process by the Dire Nursing on 9/15/10 4. Completed admission quarterly, significant and annual assessments.	ect the leeds on ent care d by the system of cation, on the change	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIS	PLE CONSTRUCTION	(X3) DATE S	
			A. BUILDING	<u> </u>	}	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL. SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	UŁO BE	(XG) COMPLETION DATE
; ; ; ; ;	bathroom of room is stains on the bathroom of stains on the bathroom of the whirlpool room the floor had areas. Interview with the D at 2:30 p.m., in the state of the floor had areas of the resident has the incompetent or other incapacitated under participate in planning changes in care and A comprehensive assinterdisciplinary tear physician, a register for the resident, and disciplines as determined to the extent profile the resident, the resident, the resident representative	O, at 8:00 a.m., in the 1310, confirmed the brown from floor. Intember 13, 2010, at 2:10 p.m. on the 300 hallway revealed of brown debris stains. ON on September 13, 2010, whirlpool room, confirmed the rown debris. D(k)(2) RIGHT TO NNING CARE-REVISE CP as right, unless adjudged the laws of the State, to ang care and treatment or	F 280	be reviewed by the At risk committee weekly to ensure that their care plans are addressing needs of the resident appropriately. The risk committee is comprised of the Administrator, Direct of Nursing, Staffing Coordinator, Minimum Dat Set Coordinator, and Medicare Nurse. 100 % of completed quarterly, significant change and annucare plans will be reviewed weekly for four weeks then completed care plans month for 3 months and/or 100% compliance. All results will reported to the Quality Assurance committee comprised of the Medical Director, Administrator, Director of Nursing, Staffin Coordinator, Minimum Dat Set Coordinator, Minimum Dat Set Coordinator, Social Services, Activities Director Dietary Manager, and Housekeeping Supervisor.	At I I I I I I I I I I I I I I I I I I I	
!	This REQUIREMEN	T is not met as evidenced				! :

09/	29/2010 10:09	9312433169		CLAY C	OUNTY MANCO	F	PAGE 11/2
		AND HUMAN SERVICES				FORM	09/20/2010 APPROVED 0938-0391
		& MEDICAID SERVICES	(VD) MI	TIDE & CO	ONSTRUCTION	(X3) DATE S	
ITATEMENT IND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUIL		NOTROL TON	COMPLE	
		445445	B. WIN	s		09/1	5/2010
NAME OF P	ROVIDER OR SUPPLIER			STREET AT	DDRESS, CITY, STATE, ZIP	CODE	
CLAY CO	DUNTY MANOR INC			111	COCKLANE A, TN 38551		
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F 280	Continued From pa		F 2	80			:
		record review and interview the ate a care plan for one (#2) of reviewed.					
	The findings includ	ed:		İ			
	11, 2010, with diag Heart Failure, Diab	dmitted to the facility on May noses including Congestive etes. Aftercare for Fracture of alking, and Esophageal Reflux.					
	Medical record revidated August 7, 20 no deficit with men	iew of the Minimum Data Set 10, revealed the resident had nory, had modified decision making, and required th two person assist for		F2	1. The order was clarified with (MD on 9/14/1) Director of Nu	the attending 0 by the using who	Completion Date 09/25/2010
	2010, revealed the need for the reside	plan updated August 10, care plan did not address the ent to require extensive sfers and ambulation.			clarified that the order was being to resident #9. was assessed of the Director of	ng administered Resident # 9 on 9/14/10 by	
	September 15, 201 office, confirmed the	OON (Director of Nursing) on 10, at 1:15 p.m., in the DON's ne care plan did not address if for extensive assistance for ulation.			noted to have to outcomes. Res assessed by his 9/25/10 who a	no adverse ident # 9 was	
F 281 SS≄D	483,20(k)(3)(i) SEI PROFESSIONAL	RVICES PROVIDED MEET STANDARDS	F	281	being given. T immediately in 9/14/10 by the	The LPN was aserviced on	

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced

9/14/10 by the Director of

mental health recommendations.

Nursing regarding policy and procedure of processing

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PRINTED: 09/20/2010 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUM. ... SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES.

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		445445	B. Wil	1G			09/15/2010
	PROVIDER OF SUPPLIER		•	120	ET ADDRESS, CITY, STAT D PITCOCK LANE ELINA, TN 38551	e, zip code	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IC) PREF TAG		(SACH GORRECTIV DROSS-REFERENCEI	AN OF CORRECTION /E ACTION SHOULD SE D TO THE APPROPRIA' CIENCY)	(X5) COMPLETION TE DATE
F 281	and interview, the findhysician's order for reviewed. The findings including Medical record reviewed admitted to the fact diagnoses including Dementia with Behand Chronic Obstruction of the findhysician and documented the result on August 9, 2 responsestaff repagitation" Further review of the recommendations and documented, recommendations and decrease oppositions of the August 9, 2010 space provided for accept the recommendations and decrease oppositions of the August 9, 2010 space provided for accept the recommendations of the August 9, 2010 space provided for accept the recommendations of the August 9, 2010 space provided for accept the recommendations of the recommenda	record review, observation, acility failed to follow a or one (#9) of 18 residents	F	281	were audite the Minimu Coordinato appropriate administere 3. The Social Departmen Director an Marketing/ Director we the establis expediting medication into physic 9/14/10 by All license inserviced 9/17/10, 9/ by the Director regarding to procedure mental hear recommen 4. All resider receiving to services we ensure tha orders are	ic medications id on 9/14/10 by im Data Set in to ensure that a corders were beinged. Services it consisting of the defendation of the Administrate on 9/15/10, 1/23/10, and 9/24/10 ector of Nursing the policy and of processing alther id on 1/23/10 and 1/24/10 ector of Nursing the policy and of processing alther idea in 1/23/10 and 1/24/10 ector of Nursing the policy and of processing alther idea in 1/23/10 and 1/24/10 ector of Nursing the policy and idea in 1/23/10 ector of Nursing the policy and idea in 1/23/10 ector of Nursing alther idea in 1/23/10 ector of Nursing alther idea in 1/23/10 ector of Nursing idea in 1/2	ns or.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION 3	GOMPL	
		445445	alw B	1G		09/	5/2010
CLAY CO	ROVIDER OR SUPPLIER DUNTY MANOR INC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	13 G	EET ADDRESS, CITY, STATE, ZIP CODE 20 PITCOCK LANE ELINA, TN 38551 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO	ORRECTION (X5)	
PREFIX TAG	REGULATORY OR	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	TAND
F 281	Interview with the recommendations residents with the services of September 14, 20 services of used for residents with acurations recommendations residents with the services office, vernot used for residents with acurations of the services of the residents with the services of the residents with acurations of the services of the residents with the services of the services of the residents with the services of the services o	the increase of the Seroquel to the been initiated. registered nurse (RN) Staff ptember 14, 2010, verified the aff had reviewed the mendation on August 24, 2010, ribed the doctor's order to the em for the pharmacy and ow. consulting NP for psychember 14, 2010, at 3:30 p.m., in office, verified there was an infor expediting medication into a physician's order for the psychological problems. RN/Staff Coordinator on 10, at 3:50 p.m., in the social iffied the expedited system was ant #9. Interview confirmed day interval from the time the was made and when the wed the order received back. Interview confirmed the	F2		be audited for three months monitor compliance or until 100% compliance is achieve All verbal orders from physicians will be audited weekly for three months by the Director of Nursing to monitor for timely approvals and signatures. All results we be reported monthly to the Quality Assurance committed comprised of the Medical Director, Administrator, Director of Nursing, Staffing Coordinator, Minimum Data Set Coordinator, Social Services, Activities Director, Dietary Manager, and Housekeeping Supervisor.	to ed. sill ee	Completion
F 315 SS=D	463,25(d) NO CAT RESTORE BLADE	HETER, PREVENT UTI, DER	F:	315	 CNA #1 and CNA #2 immediately inservice 9/14/10 regarding properciate procedures by 	d on per the	Date 09/25/2010
	assessment, the fa resident who enter indwelling cathetel resident's clinical of	lent's comprehensive acility must ensure that a is the facility without an is not catheterized unless the condition demonstrates that is necessary; and a resident			Regional Director of C Services. The Director Nursing assessed Resi after each occurrence of 9/14/10 and no advers were noted.	of dent#7 on	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) N	IULTIP	LE CONSTRUCTION	(X3) DATE S	URVEY ETED
		1.27711.00	A BU	ILDING			
		445445	B. WII	NG		09/1	5/2010
NAME OF F	PROVIDER OR SUPPLIER			1	EET ADDRESS, CITY, STATE, ZIP COD	Æ	
CLAY C	DUNTY MANOR INC			1 '	e Pitcock Lane Elina, TN 38551		
044.15	STAMMADY STA	TEMENT OF DEPICIENCIES :	ID.		PROVIDER'S PLAN OF CORF	ESCTION	(X5)
(X4) ID PREFIX TAG	· (EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION (XS)
F 315	Continued From pa	ge 6	· F:	315	2. Random pericare obser	rvations	
	who is incontinent of	of bladder receives appropriate		į	were conducted by the		
		ces to prevent urinary tract		İ	Director of Nursing an		
		store as much normal bladder			Staffing Coordinator of		
	function as possible	i. ļ		i	9/14/10, 9/15/10, and 9		:
	•	į		•	to observe for addition		:
	This REQUIREMEN	NT is not met as evidenced		j	that may need to be ad-	dressed	
	by:			ļ	with proper pericare		
		ecord review, observation, cility falled to provide		į	procedures.		
		nence care for one resident		- }	3. The licensed nurses an	d the	
	(#7) of eighteen res			i	nursing assistant staff v	was	1
	·				inserviced on pericare		i
	The finding included	‡ : [ì	procedures by the Dire	ctor of	
	l . Resident #7 was ad	imitted to the facility on			Nursing and/or the Reg		
		7, with diagnoses including			Director of Clinical Ser	rvices	
		, Alzheimer's Disease,			on 9/14/10 and 9/15/10	and as	İ
		nic Obstructive Pulmonary		Ì	well as 9/17/10 and 9/2	3/10	
	Disease and Depre	Salve Payoriosis.		ļ	by the Director of Nurs	ing	
	Medical record reviews	ew of the Minimum Data Set		į	and Staffing Coordinate	or	
		010, revealed the resident had			4. Pericare observations	will be	
		memory deficit, severely			conducted randomly	by the	
	extensive assist for	naking skills, required		i	Staffing Coordinator	on	
		I was incontinent of bowel and		•	nursing assistants for	a total of	
	bladder.			i	ten random observation	ons for	
] 	1 14 0040 -14045			one week to ensure		,
		tember 14, 2010, at 10:45 ts room, revealed CNA#1			appropriate incontines	nce care	
	a.m., m the residem (certified nursing as			i	is being provided. The	en five	
		Continued observation			random pericare obser	rvations	1
		1 removed the wet brief and			on all three random sh	iifts will	1
		n the resident without cleaning		ļ	be conducted each we	ek for	
	the perineal area.			İ	three months or until	100%	ļ
] : Interview with the C	NA #1 on September 14.		1	compliance is achieve	d by the	1
		, in the hallway, confirmed			Staffing Coordinator.	Random	

DÉPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) N A. Bù		IPLE CONSTRUCTION IG	COMPLE	
		445445	a. Wir	۷G _		09/1	5/2010
	PROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 120 PITCOCK LANE CELINA, TN 38551		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOTO CROSS-REFERENCED TO THE APPLIED TO THE	OULD BE	COMPLETION DATE
	provided. Observation on Sep.m., in the resident providing incontinued observation wet brief, position performed incontinuating a non rinse son the back, and provided the front area. Interview with RN # September 14, 201 confirmed CNA #2 incontinence care.	otember 14, 2010, at 3:30 It's room, revealed CNA #2 Ince care to the resident. Ition revealed CNA #2 removed oned resident on the side, ance care to the buttocks area olution, positioned the resident rovided incontinence care to It (registered nurse) on 0, at 3:55 p.m., in the hallway, did not perform appropriate During the interview, RN #1 an the least dirty to the most	· · · F :	315	observations will be completed on all certific nursing assistants during audit. All results will be reported monthly to the Quality Assurance common comprised of the Medica Director, Administrator, Director of Nursing, Sta Coordinator, Minimum Set Coordinator, Minimum Set Coordinator, Social Services, Activities Directory Manager, and Housekeeping Supervise	the mittee al ffing Data ector,	
SS≃D	environment remain as is possible; and adequate supervising prevent accidents. This REQUIREMENT by: Based on medical rand interview the face as the second preview the second prev		F	323	F323 1. Resident #2 had an in audit of her care plant Director of Nursing to that gait belt use was planned for her care. # 2 was assessed by a Registered Nurse upo incident, 08/10/2010 adverse outcomes. The Certified Nursing Asseno longer employed b facility as of 8/10/10.	by the care care Resident on with no se sistant is	Completion Date 09/25/2010

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DEPARTMENT OF HEALTH AND HUM, ... SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT AND FLAN OI	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUI		NG	COMPLE	TED
		445445	B. WIN	اچا		09/1	5/2010
NAME OF PE CLAY CO (X4) ID PREFIX TAG	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENT REGULATORY OR Continued From pappropriate incomprovided. Observation on Sp.m., in the reside providing incontinued observation the wet brief, positive wet brief, positive performed incontinued incontinued observation on the back, and the front area. Interview with RN September 14, 20 confirmed CNA # incontinued care	A45445 ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION:		STF 1 C	REET ADDRESS, CITY, STATE, ZIP CODI 126 PITCOCK LANE CELINA, TN 38551 PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE ALD DEFICIENCY)	ent care d by the solution. a Set asserviced aing ctor of . The]
F 323 SS=D	dirty." 483.25(h) FREE HAZARDS/SUPE The facility must environment rem as is possible; ar adequate superv prevent accidents This REQUIREM by: Based on medical	OF ACCIDENT RVISION/DEVICES ensure that the resident ains as free of accident hazards id each resident receives ision and assistance devices to		323	certified nursing as and licensed nurse	sistants s on nd 9/23/10 on gait belt on, nt change nents will At risk to ensure s are f the	

FRINTED: USIZUIZUTU FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES <u>OMB_NO_0938-0391</u> CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A BUILDING e. WING 09/15/2010 445445 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 120 PITCOCK LANE CLAY COUNTY MANOR INC CELINA, TN 38551 (X6) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ΙĐ (EACH CORRECTIVE ACTION SHOULD BE PREFIX (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG DEFICIENCY) TAG risk committee is comprised F 323i F 323 Continued From page 8 of the Administrator, Director The findings included: of Nursing, Staffing Coordinator, Minimum Data Resident #2 was admitted to the facility on May Set Coordinator, and 11, 2010, with diagnoses including Congestive Heart Failure, Diabetes, Aftercare for Fracture of Medicare Nurse. 100 % of Leg, Difficulty in Walking, and Esophageal Reflux. completed quarterly and annual assessments will be Medical record review of the Minimum Data Set reviewed weekly for four dated August 7, 2010, revealed the resident had weeks then 25 completed care no deficit with memory, had modified independence for decision making, required

extensive assist for transfers and ambulation.

Interview with the DON (Director of Nursing) on September 15, 2010, at 1:15 p.m., in the DON's office, confirmed the CNA transferred the resident without using a gait belt. Continued interview revealed certified nursing assistants are to use a gait belt at all times during transfer of the residents.

F 431 | 483,60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS SS=D:

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically

plans monthly for 3 months and/or 100% compliance. Gait belt use observations will be conducted randomly by the Staffing Coordinator on

nursing assistants for a total of ten random observations for one week to ensure appropriate incontinence care is being provided. Then five random gait belt use observations on all three random shifts will be conducted each week for three months or until 100% compliance is achieved. Random observations will be completed on all certified

Event ID: OJKE11

F 431

(X5) COMPLETION (IATE

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FORM APPROVED

DEPARTMENT OF HEALTH AND HUM. SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER.

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D9/15/2010

tĐ

PREFIX

TAG

F 323

NAME OF PROVIDER OR SUPPLIER

CLAY COUNTY MANOR INC

(X4) ID

PREFIX

TAG

STREET ADDRESS, CITY, STATÉ, ZIP GODE 126 PITCOCK LANE

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

CELINA, TN 38551

F 323 Continued From page 8
The findings included:

Resident #2 was admitted to the facility on May

SUMMARY STATEMENT OF DEFICIENCIES

FACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

Resident #2 was admitted to the facility on May
11, 2010, with diagnoses including Congestive
Heart Failure, Diabetes, Aftercare for Fracture of
Leg, Difficulty in Walking, and Esophageal Reflux.

Medical record review of the Minimum Data Set dated August 7, 2010, revealed the resident had no deficit with memory, had modified independence for decision making, required extensive assist for transfers and ambulation.

Review of the facility's documentation dated August 10, 2010, revealed the resident sustained a non-injury fall in the shower room. Continued review revealed CNA (certified nursing assistant) transferred the resident without using a gait belt.

Interview with the DON (Director of Nursing) on September 15, 2010, at 1:15 p.m., in the DON's office, confirmed the CNA transferred the resident without using a gait belt. Continued interview revealed certified nursing assistants are to use a gait belt at all times during transfer of the residents.

F 431 483.60(b), (d), (e) DRUG RECORDS, SS=D LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically

nursing assistants during the audit. All results will be reported to the Quality Assurance committee comprised of the Medical Director, Administrator, Director of Nursing, Staffing Coordinator, Minimum Data Set Coordinator, Social Services, Activities Director, Dietary Manager, and Housekeeping Supervisor.

F431

F 431

 The Aspirin and Kao-tin were immediately destroyed on 9/14/10 by LPN #1. The LPN was inserviced on 9/14/10 by the Director of Nursing on proper destruction of expired medications. Completion Date 09/25/2010

If continuation sheet Page 9 of 14

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NUMBER: A BUILDING		COMPLETED	
	445445	S. Wil	NG	09/15/2010	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 PITCOCK LANE		
CLAY COUNTY MANOR INC		CELINA, TN 38551			
	ATTACANT OF DESIGNATES	10	PROVIDER'S PLAN OF CORRECT	TION (X5)	

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE
DEFICIENCY)

F 431

F 431 Continued From page 9 reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced

Based on observation and interview the facility failed to ensure all medications provided in one of two medication carts available for resident use did not have expired use dates.

The findings included:

Observation with the licensed practical nurse (LPN #1), in the 300 hallway, of medications contained in the "300 hail" medication cart, on

- 2. All medications and medical supplies were audited by the Director of Nursing, Minimum Data Set Coordinator, Staffing Coordinator, and Medicare Nurse on 9/14/10 to ensure that all items had appropriate dates. No residents were identified as being affected by this.
- 3. The licensed nurses were inserviced on 9/21/10, 9/22/10, and 9/23/10 regarding procedures for appropriately dated
 - medications and medical supplies by the Director of Nursing.
- 4. All medications and medical supplies will be monitored by the Director of Nursing daily for five days to ensure all medications provided in medication carts available for resident use does not have expired use dates. The medications and medical supplies will then be monitored by the Medicare Nurse Supervisor two times per week for three months or

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FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER A. BUILDING B. WING 445445 09/15/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 120 PITCOCK LANE CLAY COUNTY MANOR INC CELINA, TN 38551 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL !D (X4) ID PREFIX DATE **PREFIX** REGULATORY OR USC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY until 100% compliance is F 431 F 431 Continued From page 10 achieved. All results will be September 14, 2010, at 8:30 a.m., revealed the reported monthly to the following: 1) a bottle of Aspirin EC (enteric coated Quality Assurance committee aspirin) 300mg, supplied with 100 tablets per container, had approximately 30 pills remaining comprised of the Medical with an expiration date of October 2009; and 2) Director, Administrator, Kao-tin (a medication for diarrhea), supplied in an Director of Nursing, Staffing 8 ounce bottle, had three-fourths of the liquid Coordinator, Minimum Data medication remaining, and an expiration date of Set Coordinator, Social October 2009. Services, Activities Director, Interview with LPN #1, at the time of the Dietary Manager, and observation, confirmed the two stock medications Housekeeping Supervisor. had been out of date for the previous eleven months. F 441 F441 Completion F 441 483,65 INFECTION CONTROL, PREVENT Date SS=D | SPREAD, LINENS 9/25/2010 1. LPN #3 was immediately The facility must establish and maintain an inserviced on 9/13/10 by the Infection Control Program designed to provide a Director of Nursing regarding safe, sanitary and comfortable environment and maintaining Infection Control to help prevent the development and transmission standards during wound of disease and infection. treatments. The wound for (a) Infection Control Program Resident # 7 was assessed by The facility must establish an Infection Control the Director of Nursing on Program under which it -9/13/10 with no adverse (1) investigates, controls, and prevents infections affects noted. in the facility; 2. Wound treatment observations (2) Decides what procedures, such as isolation, should be applied to an individual resident; and were conducted by the (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection. (1) When the infection Control Program determines that a resident needs isolation to

prevent the spread of infection, the facility must

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED <u>OMB NO. 0938-0391</u>

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1; PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED DENTIFICATION NUMBER. AND PLAN OF CORRECTION A. BUILDING E WING 09/15/2010 445445 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 120 PITCOCK LANE CLAY COUNTY MANOR INC CELINA, TN 38551 PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ED (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE FRECEDED BY FULL DATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) Director of Nursing and a F 441 F 441 Continued From page 11 Registered Nurse on 9/14/10, isolate the resident. 9/15/10, and 9/16/10 to (2) The facility must prohibit employees with a observe for additional areas communicable disease or infected skin lesions from direct contact with residents or their food, if that may need to be addressed direct contact will transmit the disease. with proper infection control (3) The facility must require staff to wash their procedures. hands after each direct resident contact for which The licensed nurses were hand washing is indicated by accepted inserviced on 9/21/10. professional practice. 9/22/10, and 9/23/10 by the (c) Linens Director of Nursing regarding Personnel must handle, store, process and procedures for maintaining transport linens so as to prevent the spread of Infection Control standards infection. during wound treatments. 4. Wound treatment observations will be conducted randomly to This REQUIREMENT is not met as evidenced ensure proper infection control procedures for wound Based on facility procedure review, observation, and interview the facility failed to ensure infection care are being used. The control strategies were maintained for one of one Director of Nursing and/or dressing change observed. Staffing Coordinator will be observing wound treatment on The findings included: Licensed Nurses for a total of Review of the facility's Basic Infection Control ten random observations to Procedure for Wound Care revealed the stated include observations of every purpose was, "To prevent cross-contamination nurse for one week. Then five among residents as well as between residents random wound treatment and caregivers." Review of the procedure observations will be revealed steps 2, 5 and 6 as follows, "2, Prepare clean field with necessary equipment...5. Remove conducted each week for three soiled dressing...place in bag...Remove gloves months or until 100% and discard...6. Wash hands...' compliance is achieved by the Staffing Coordinator. All Observation on September 13, 2010, at 1:30 results will be reported p.m., of licensed practical nurse (LPN #3), revealed the LPN preparing supplies outside of

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION		(X1: PROVIDER/SUPPLIER/OLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445445	A WING		09/1	5/2010	
	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODI 120 PITCOCK LANE CELINA, TN 38551			
(X4) ID PREFIX TAG	/FACH DEFICIENC	(TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE PPROPRIATE	(X5) COMPLETION DATE	
F 441	Observation continuous breaches in infection dropped the tube of room, retrieved it for back with the other the ulcer with norm of a previous dress the wound), and piblichazard bag had 3) picked up the turn gloves worn to clear removed gloves, a gloves without was interview at the nursulation at 2.30 p.m. (who had entered dressing change),	n for a dressing change. ued and revealed the following on control practices: 1) the LPN of medication upon entering the committee floor, and placed it clean supplies; 2) cleansed hal saline and removed the partising (still adhered to the right of aced these items on the bed, a not been brought to the room; be of medication with the same anse the ulcer, then put down, and began to don another pair of	F 44	monthly to the Quality Assurance committee comprised of the Medi Director, Administrate Director of Nursing, S Coordinator, Minimur Set Coordinator, Socia Services, Activities D Dictary Manager, and Housekeeping Superv F502 1. The lab tubes were immediately destro LPN #4 on 9/14/10 was immediately in on checking expire the Director of Nur 9/14/10. 2. All medications an	ical or, taffing n Data al irector, isor. yed by D. LPN #4 ascrviced d tubes by rsing on	Completion Date 9/25/2010	
F 502 SS≃D	The facility must p services to meet t facility is responsit of the services. This REQUIREMED by: Based on observational failed to ensure of used by the nursing services.	provide or obtain laboratory the needs of its residents. The pole for the quality and timeliness and interview the facility the of three types of blood tubes, and svailable to resident use,	F 50	sumplier warn andi	ted by the g, t ing Medicare o ensure oppropriate ing staff was Director of 0, 9/22/10, ling ropriately		

FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES						FORM APPROVED OMB NO. 0938-0391		
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/GLIP IDENTIFICATION NUMBER	(X2; MI	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED 09/15/2010		
		445445	8 WIN		09/15/			
	/EACH DESIGIENC	ATEMENT OF DEFICIENCIES Y MUS" BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	ID PREFI TAG		RRECTION ;	(X5) COMPLETION DATE		
	a.m., with the licen in the medication rubes used by the samples, revealed expiration date of During interview, a LPN #4 stated, "Was supplies to use	ptember 13, 2010, at 10:30 sed practical nurse (LPN #4), com, of the three types of lab staff when drawing blood the "blue top" tubes had an	F	medical supplies. 4. All medications and supplies will be monthe Director of Nursifor five days to ensurble blood tubes used by nursing staff when plaboratory services a available to resident within the expiration. The medications and supplies will then be monitored by the Mc Nurse Supervisor two per week for three muntil 100% compliar achieved. All results reported monthly to Quality Assurance of comprised of the Mc Director, Administrate Director of Nursing, Coordinator, Minimus Set Coordinator, Minimus Set Coordinator, Soo Services, Activities in Dietary Manager, and Housekeeping Super	nitored by ing daily re all lab the roviding ind use, were i date. I medical edicare to times conths or ince is will be the committee edical utor, Staffing um Data cial Director, id			